

The Federal Home Visiting Program Demographic, Service Utilization, and Select Clinical Indicators and Performance Indicators and Systems Outcomes Frequently Asked Questions (FAQs) May 2016

The Health Resources and Services Administration’s (HRSA) Maternal and Child Health Bureau (MCHB) revised the Home Visiting Program performance measurement system, which was approved by the Office of Management and Budget (OMB) in March 2016. This FAQ includes commonly-asked questions about the new requirements for the performance measurement system and is one of several technical assistance resources to support Federal Home Visiting Program grantees in adopting and implementing the new performance measures.

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FORM 1: Demographic, Service Utilization, and Select Clinical Indicators

General

- 1. Grantees will end data collection on previous Form 1 measures September 30, 2016 and begin data collection with new Form 1 measures October 1, 2016. How do we address clients who were enrolled under the previous system, but will continue to receive services after we roll out the new measures? Will we transfer those clients to the new system or collect information on both sets of Form 1 measures?**

A: Grantees will be required to begin data collection for continuing families using the revised measures on October 1, 2016. They will cease data collection using the old system and transfer all participants to the new measures. Participants who roll over to the new system will need to be reassessed annually using the new measures on or after October 1, 2016 and will be considered continuing enrollees.

- 2. For Form 1, how should we report the status of enrollees and when are the data expected to be collected?**

A: All Form 1 data should be collected at the time of enrollment and updated annually thereafter. Below are a few scenarios that may be helpful when reporting enrollee status:

- If a woman is pregnant at the time she enrolls in the home visiting program, she should be counted as pregnant, even if she completes her pregnancy within the same reporting period. If she continues enrollment after pregnancy into subsequent reporting periods she would be counted as a female caregiver.
- If a woman is enrolled as a female caregiver and becomes pregnant in the same reporting period with a sibling of the enrolled index child, she will continue to be counted as a female caregiver since grantees will report her status at the time of enrollment.
- If a woman is pregnant at the time she enrolls and the index child is born during the reporting period, the index child is considered a new enrollee at the time of birth and should be counted in that reporting period.

- 3. There are some entries that may change over time (education, employment). Should we use the most recent entry or the entry at enrollment? How often should data be collected on these entries as participants continue receiving services?**

A: For participants who are newly enrolled, Form 1 data should be collected at the time of enrollment. Data should be updated annually thereafter for participants continuing enrollment in subsequent reporting periods. It is up to grantees to establish procedures for updating Form 1 data on an annual basis.

4. What is the frequency of data collection for Form 1 data?

A: Participants will be assessed at the time of enrollment and then annually thereafter.

5. How will the data collection requirements for the Form 1 demographics align with data collection required by each of the models?

A: HRSA is working with models to identify how model data collection will align with the new performance measures. DOHVE is also collecting details on model data collection to provide grantees with a model developer data crosswalk to support grantees in organizing their data collection efforts.

6. Are the terms “newly enrolled” and “continuing during reporting period” being considered in the same manner on Forms 1 and 4?

A: For the purposes of Form 1, new participants are participants who sign up to participate in the home visiting program at any time during the reporting period and who are served by a trained home visitor implementing services with fidelity to the model for whom at least 25% of his/her personnel costs are paid for with MIECHV funding.

For the purposes of Form 1, continuing participants are participants who were signed up and enrolled in the home visiting program prior to the beginning of the reporting period who were served by a trained home visitor implementing services with fidelity to the model for whom at least 25% of his/her personnel costs are paid for with MIECHV funding.

The definition of continuing participants differs slightly from Form 4 Table A.1 because of the cross-sectional nature of that table. You can access definitions and Frequently Asked Questions for Form 4 at: <http://mchb.hrsa.gov/programs/homevisiting/ta/resources/index.html>.

Participant Demographics

7. For Table 2: Unduplicated Count of Households Served by MIECHV Home Visitors, is there a difference in the definition for the number of newly enrolled? The phrase “...and continued enrollment” is included in the current definition and does not include those who disenrolled.

A: The definition has been updated to remove the phrase “...and continued enrollment.” All participants who were served during the reporting period should be reported in Table 2.

8. For Table 3: Unduplicated Count of Participants and Households Served by State Home Visiting Programs, is this the only place we are reporting on the non-MIECHV participants?

A: Yes.

9. For Table 3: What is the intent of collecting information on non-MIECHV programs?

A: HRSA's intent for collecting participant information for non-MIECHV evidence-based and promising approach home visiting programs is to better document the reach of the Federal Home Visiting Program. Federal Home Visiting Program grantees use federal grants to leverage additional funding to expand their evidence-based home visiting services. Documenting the scope of those services will allow HRSA to better convey the complete scope of the Federal Home Visiting Program.

10. For Table 3: Unduplicated Count of Participants and Households Served by State Home Visiting Programs, should other programs that are not MIECHV-funded or evidence-based also be included?

A: Any evidence-based home visiting program or program that qualifies as a promising approach and is overseen by the same entity that receives the MIECHV grant should be included in Table 3.

11. How is HRSA defining a "program that qualifies as a promising approach"? Will this be restricted to only non-EB models that have already been submitted to HomVEE for review? Is it any non-EB home visiting model?

A: A home visiting service delivery model that qualifies as a promising approach is defined in the statute as the following: "the model conforms to a promising and new approach to achieving the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), has been developed or identified by a national organization or institution of higher education, and will be evaluated through well-designed and rigorous process."

12. For Table 12: Adults Participants by Housing Status, can you clarify the definitions for each category?

A: Table 12 is a tiered table. Grantees must first determine whether each adult participant is homeless, according to the definition provided in the Key Terms for Form 1. Grantees must then assess the current housing status of each adult participant. Definitions for the categories under "Homeless" are provided in the Key Terms. Grantees should categorize participants according to the category that most closely matches the participant's housing status.

13. For Table 15: Priority Population Characteristics for Each Household, how do we account for duplication if families meet multiple priority populations?

A: All enrolled families should be represented in each row.

- 14. For Table 15: Priority Population Characteristics for Each Household, does HRSA want us to report individual or family income?**

A: Grantees should collect and report information on household income for this table.

- 15. For Table 15: Priority Population Characteristics for Each Household, will this be limited to only newly enrolled families?**

A: No, all participants should be included in Table 15. Participants should be assessed at program enrollment and annually thereafter.

- 16. For Table 17: Family Engagement by Household, which families would be included under the category “enrolled but not currently receiving services”?**

A: Programs should defer to home visiting model or program definitions for the purposes of this category.

- 17. For Table 18: Unduplicated Count of Home Visitor FTE, are grantees expected to report on the number of FTE home visitors supported by grant funds over the entire reporting period, or are they supposed to report on the number of home visitor positions?**

A: Grantees are expected to report on the cumulative FTE home visitors employed during the reporting period, not the number of positions filled.

Insurance and Clinical Indicators

- 18. For Table 20: Participants by Type of Health Insurance Coverage, our Medicaid allows for retroactive insurance coverage. How should we take this into account for Table 20?**

A: Grantees should assess insurance status at the time of enrollment and then annually thereafter. Grantees should report the known status at the time of assessment.

- 19. For Table 21: Index Children by Usual Source of Medical Care, within one six month period, we will have multiple answers (e.g., have a physician but have also been seen in urgent care). Is there a hierarchy if multiple types of care occur for the same index child?**

A: Grantees should report the *usual* source of care for the family at enrollment and annually thereafter. This table is not intended to document all sources of medical care during the reporting period.

20. For Table 21: Index Children by Usual Source of Medical Care, where should urgent care be included?

A: Urgent care is a term describing the provision of immediate medical services in an outpatient setting for acute or chronic illness¹ and does not necessarily describe a particular setting of care. Urgent care may be provided in many of the categories outlined in Table 21. The grantee should attempt to determine which category provided in Table 21 most closely aligns with the setting for the provision of urgent care and classify it appropriately. If no category aligns closely, the index child should be counted in the “Other” category and details should be described in the “Notes” section.

¹ American Academy of Urgent Care Medicine. “What is Urgent Care” accessed from <http://aaucm.org/about/urgentcare/default.aspx>

FORM 2: Performance Indicators and Systems Outcomes

General

- 21. Grantees will end data collection on previous performance measures September 30, 2016 and begin data collection with new performance measures October 1, 2016. How do we address clients who were enrolled under the previous system, but will continue to receive services after October 2016? Will we transfer those clients to the new system or collect information on both sets of performance measures?**

A: Grantees will be required to begin data collection for continuing families using the revised performance measures on October 1, 2016. They will cease data collection using the old system and transfer all participants to the new performance measures.

For Form 2, grantees will need to be assessed with the new performance measures based on the eligibility criteria for each measure. This may result in some participants rolling over to the new measures not being assessed if they missed the data collection point and are no longer eligible for a given measure.

- 22. How should we address missing data? Should we only include participants for which we collected data in the denominator or should we include all eligible participants?**

A: Only include participants with complete data in the calculation of the percentage or rate. Missing data will affect the accuracy of the data and could misrepresent program performance. Grantees are expected to take all necessary efforts in order to minimize missing data. This includes using proper data collection forms, training staff on data collection protocols, ensuring data are entered in proper data systems, and monitoring data quality and accuracy regularly. Missing data will be considered during the review of annual performance data. Grantees should consult with DOHVE Liaisons on how to account for missing data.

- 23. Are we required to report on families served by home visitors who receive 25% or more of their funding from MIECHV?**

A: Yes; all participants who are served by a trained home visitor implementing services with fidelity to the model for whom at least 25% of his/her personnel costs are paid for with MIECHV funding should be reported.

- 24. How will the data collection requirements for the benchmarks align with data collection required by each of the models?**

A: HRSA is working with models to identify how model data collection will align with the new performance measures. DOHVE is also collecting details on model data collection to provide

grantees with a model developer data crosswalk to support grantees in organizing their data collection efforts.

25. What is considered a validated tool?

A: A validated tool is an instrument that has been psychometrically tested for reliability, validity, sensitivity, and specificity. A reliable tool is both consistent and stable at measuring a construct. A valid one measures the concept it was intended to measure. Sensitivity represents the degree to which an instrument correctly identifies those individuals who have a specific condition. Specificity is the degree to which an instrument correctly screens out those individuals who do not have a specific condition.

Grantees need to ensure they follow the administration and training protocols of the tool they select to ensure they are being used appropriately. Some measurement tools have specific training requirements that need to be met before staff can administer the tool. Grantees should always select tools that ensure fidelity to the guidelines of the evidence-based home visiting model or model that qualifies as a promising approach, as applicable.

26. Several measures ask for a validated tool (e.g. Measure 10: Parent-Child Interaction). Will a list of validated tools be provided to grantees?

A: HRSA does not endorse specific tools, but requires grantees to use validated tools to assess caregiver-child interaction and to screen families for maternal depression, intimate partner violence, and child developmental delays. Grantees have the discretion to select validated tools that are appropriate and in accordance with model guidelines. To support grantees in identifying validated tools, DOHVE has included examples of validated tools in DOHVE's *Form 2 Performance Indicators and Systems Outcomes Data Collection and Reporting Manual and Plan*. These examples do not constitute an endorsement of the instrument by the authors, the publishers, DOHVE, or HHS.

27. Are there specific or required data sources for each construct?

A: Grantees should use self-report for all Form 2 measures except for Measure 9: Child Maltreatment. HRSA requires child maltreatment data to be collected from child welfare administrative records. For all other measures, self-report should be used unless the grantee would prefer to use data from another reliable source, like birth certificate data.

28. For several measures, there are no instructions for the timing of data collection. At which time points should we collect data?

A: If the timing of the data collection is not specified, the grantee *may* collect data at or near the end of the reporting period (although more routine data collection may be preferred for some measures). This will require grantees to monitor which home visits will fall closest to the end of the reporting period for each family to ensure data collection is complete for each family.

For some measures, the timing of data collection is specified in the numerator and denominator definition of the measure. Grantees should follow the criteria specified in these measures. Additional information may be found in DOHVE's *Form 2 Performance Indicators and Systems Outcomes Data Collection and Reporting Manual and Plan*.

29. How should we address measures that require the collection of numerous pieces of data (e.g. Measure 6: Tobacco Cessation Referrals)?

A: Grantees will need to meet all the criteria specified in the definition of the measure. For example, to be counted in the numerator of Measure 6, a primary caregiver needs to have been a user of tobacco or cigarettes at the time of enrollment and referred to tobacco cessation counseling or services within 3 months of enrollment. This will require the grantee to collect multiple data elements in order to assess this measure: (1) tobacco or cigarette use at the time of enrollment, (2) documentation of referral to tobacco counseling or cessation services, and (3) date of referral. For additional support in identifying the needed data elements, please see DOHVE's *Form 2 Performance Indicators and Systems Outcomes Data Collection and Reporting Manual and Plan* or check with your DOHVE TA Liaison.

30. If we have a family with two primary caregivers, should we include one or both primary caregivers?

A: Only one primary caregiver should be reported per family. For home visiting models that allow programs to enroll more than one adult participant, only one adult participant per family may be the primary caregiver for the purposes of reporting. The adult participant identified as the primary caregiver is the participant that should be assessed.

31. Does the denominator only include children or families enrolled during the reporting period?

A: The denominator for all performance measures should include participants who were enrolled in services during the reporting period. Participants who were enrolled in previous reporting periods but did not receive services during the current reporting period will not be included in the denominator.

32. How do we address participants who have been enrolled for different lengths of time at the end of each reporting period? Can the measurement period be defined so that it is consistent across grantees?

A: Different enrollment periods across participants are acceptable. Information should be collected within applicable specified time periods in accordance with measure definitions or at the home visit closest to the end of the reporting period.

33. Are families reported on twice for the same measure if they remain eligible across multiple reporting periods?

A: Some measures are collected at one point in time per family, whereas families are assessed in multiple reporting periods for other measures, depending on the measure criteria. See DOHVE's

Form 2 Performance Indicators and Systems Outcomes Data Collection and Reporting Manual and Plan for more information regarding data collection for each measure.

34. Can we use the last home visit as a proxy for exiting from the program when there has been a period of inactivity?

A: If the denominator specifies inclusion criteria that is time-bound (e.g., participants enrolled for at least 6 months), then that criteria must be met in order to be included in the measure. The last home visit may be used as a proxy for exiting from the program so long as inclusion does not violate criteria for being counted in the measure.

35. Are these measures the same as for the Tribal Home Visiting Program?

A: The Administration on Children and Families (ACF) has developed separate performance measures for grantees who receive funding under the Tribal Home Visiting Program, administered by ACF.

Preterm Birth

36. We do not target prenatal enrollment and may subsequently have low numbers to report for this measure. How should we address potentially low numbers or no participants who meet the inclusion criteria?

A: Participants only need to be included in the reporting for a measure if the inclusion criteria for that measure are met. If a program model does not serve the target population for a measure (e.g., does not enroll participants prenatally), then there are no eligible participants to be included in the denominator. HRSA recognizes that some program models do not enroll participants prenatally.

37. Will this measure include women up to and at 37 weeks or do they have to enroll before 37 weeks (i.e. 36 weeks and below)?

A: To be included in this measure, a primary caregiver must enroll before entering 37 weeks (36 weeks 6 days) gestation. Grantees must include all primary caregivers who are enrolled prenatally prior to 37 weeks (i.e. 36 weeks and 6 days or less) in the denominator. To be counted in the numerator, grantees must include all primary caregivers who deliver a live birth before 37 completed weeks of gestation (i.e. 36 weeks and 6 days or less).

38. How is HRSA defining preterm birth?

A: Preterm birth is defined as the birth of an infant at less than 37 weeks (36 weeks 6 days) of gestation².

² Behrman R, Stith Butler A. eds. *Preterm Birth: Causes, Consequences, and Prevention*. Washington, DC: The National Academies Press, 2007.

39. If a mother enrolled at 36 weeks and gives birth within the 36th week, would she still be considered in the numerator and denominator?

A: Yes; she will be included in the numerator and the denominator because she meets the criteria for both.

40. If we have birth certificate information, should we use that or use self-report?

A: Grantees should use self-report for all Form 2 measures (except Measure 9: Child Maltreatment) unless the grantee would prefer to use data from another reliable source, like birth certificate data.

41. Are there any exceptions or exclusions for preterm birth with regards to women giving birth to multiples?

A: No; this measure applies to all births that meet the eligibility criteria as defined in the measure.

Breastfeeding

42. We do not target prenatal enrollment and may subsequently have low numbers to report for this measure. How should we address potentially low numbers or no participants who meet the inclusion criteria?

A: Participants only need to be included in the reporting for a measure if the inclusion criteria for that measure are met. If a program does not serve the target population for a measure (e.g., does not enroll participants prenatally), then there are no eligible participants to be included in the denominator. HRSA recognizes that some program models do not enroll participants prenatally.

43. Does it count if an infant is breastfed consistently up until 5 months, but is not breastfed any amount at 6 months?

A: No; the infant must be breastfed any amount at 6 months of age to be included in the numerator for this measure.

44. How do we address index children who are 6 months old and have been breastfed at 6 months, but have only been enrolled for 3 months?

A: To be included in this measure, mothers must have been enrolled prenatally, be enrolled for at least 6 months, and the index child must have reached 6 months of age. Therefore, an index child enrolled for only 3 months should not be included in this measure.

45. How do we address mothers who could not continue breastfeeding at 6 months postpartum due to medical complications or difficulties?

A: Mothers who are not recommended to breastfeed due to certain medical conditions should be excluded from this measure. Medical exclusion criteria can be found at <http://www.cdc.gov/breastfeeding/disease/>

46. The numerator and denominator include the number of infants aged 6 to 12 months who are enrolled for at least 6 months. Is this based on the end of the reporting period or is this at any time?

A: To be included in this measure, the primary caregiver must have enrolled prenatally and the index child must be 6 to 12 months old during the current reporting period. Families that meet this criterion during the reporting period should be included in this measure.

47. What is the window for data collection? What are the parameters to be included in the denominator?

A: This measure assesses breastfeeding that occurred when the index child was 6 months of age. The data may be collected when the index child is anywhere between 6 and 12 months of age, but must reflect whether breastfeeding occurs at 6 months of age for infants who's mothers were enrolled prenatally and were enrolled for at least 6 months.

Depression Screening

48. Does the denominator need to be changed to capture both populations listed in the numerator? For example, instead of “number of caregivers enrolled for 3 months” in the denominator, it would be “number of caregivers not enrolled prenatally who have been enrolled 3 months and number of caregivers who enrolled prenatally who are at least 3 months postpartum”?

A: This performance measure was revised so that the inclusion criteria for the target population in the denominator match those of the numerator. The most up-to-date performance measures can be found at the following website: <http://www.mchb.hrsa.gov/programs/homevisiting/ta/resources/index.html>.

49. What if we are currently only screening pregnant (or postpartum) women? Do we need to expand our data collection to include all mothers?

A: Yes; grantees must screen all primary caregivers for depression. For programs that currently screen a narrower target population (e.g., pregnant mothers or postpartum mothers), data collection will need to be expanded to include all primary caregivers who meet eligibility criteria. The screening is only required for one primary caregiver per family.

Well-Child Visits

50. When are data for this measure supposed to be collected?

A: Data regarding well-child visits may be collected by the grantees after each scheduled well-child visit or retrospectively at the end of the reporting period. This will require grantees to monitor which home visit will fall closest to the end of the reporting period for each family to ensure data collection is complete.

51. Is this intended to measure whether children are up to date on visits according to American Academy of Pediatrics (AAP) schedule or whether they received their last expected visit according to the AAP schedule? For example, a child may not have received most of their intended visits but did receive their last expected visit according to the AAP schedule. Should they be counted in this measure?

A: This measure does not assess if the index child is up to date on well-child visits, but if the last recommended visit was completed based on the index child's current age. To determine if the recommended visit occurred, grantees should use the American Academy of Pediatrics (AAP)-informed intervals (as specified in DOHVE's *Form 2 Performance Indicators and Systems Outcomes Data Collection and Reporting Manual and Plan*), which are based on the AAP schedule (https://www.aap.org/en-us/Documents/periodicity_schedule.pdf) and depend on the index child's age. Index children will be counted in each reporting period in which they were enrolled for any length of time.

52. What if a child was up to date on well-child visits as of their last home visit, but the family dropped out? Does it count if they were up to date on well-child visits as of their last home visit?

A: An index child should be included in the numerator for this measure if they had their last recommended well-child visit at the time of their last home visit. Programs should use the last completed well-child visit prior to the home visit. For example, following the AAP periodicity schedule, each index child should receive a well-child visit during the following intervals depending on their age: 3-7 days, 2-4 weeks, 2-3 months, 4-5 months, 6-7 months, 9-10 months, 12-13 months, 15-16 months, 18-19 months, 2-2.5 years, 3-3.5 years, 4-4.5 years. If the index child passes 6 months of age at the end of the reporting period and is expected to have received the 6 month well-child visit, but the last home visit was at 5 months of age, then the 4-month expected well-child visit should be used as the last completed well-child visit data collection point.

53. Is there any flexibility around the AAP schedule? For example, what if a child has a well-child visit one week after the exact scheduled day? What are the parameters to be included in the denominator?

A: Index children will be counted in each reporting period in which they were enrolled for any length of time. Grantees should use the following intervals, which are based on the AAP schedule (https://www.aap.org/en-us/Documents/periodicity_schedule.pdf) and depend on the index child's age: 3-7 days, 2-4 weeks, 2-3 months, 4-5 months, 6-7 months, 9-10 months, 12-13

months, 15-16 months, 18-19 months, 2-2.5 years, 3-3.5 years, 4-4.5. These intervals allow for a window for the visits to occur. For instance, the 9 month visit could occur anytime between when the index child is 9 to 10 months of age.

54. Is the denominator all index children enrolled or just those enrolled at the time of a recommended well child visit?

A: All index children enrolled in the home visiting program will be included in the denominator.

Postpartum Care

Tobacco Cessation Referrals

55. What does “at enrollment” mean when a family enrolled in a prior reporting period? Does the denominator include participants who indicated using tobacco at enrollment, even if they enrolled in a prior reporting period?

A: Yes; primary caregivers indicating tobacco or cigarette use at enrollment should be included in the reporting period in which they reached 3 months post-enrollment. This means that they could be screened for tobacco or cigarette use in one reporting period and reach 3 months post enrollment in the next.

56. The performance measure definition refers to “primary caregivers.” We currently only screen pregnant (or postpartum) women for tobacco use. Do we need to expand data collection to include all primary caregivers?

A: Grantees should report tobacco or cigarette use for the primary caregiver only (only one primary caregiver per household). For grantees that currently limit data collection to a sub-population of primary caregivers, then data collection should be expanded so that all primary caregivers are assessed for this measure.

57. Will the denominator continue growing to include people who are enrolled every year? While the numerator only reflects one year?

A: This measure is collected at one point in time per family, at 3 months following enrollment.

58. Do we need to ask the client about their tobacco use every year?

A: For the purposes of this measure, tobacco or cigarette use only needs to be assessed at enrollment.

59. What is the definition of a referral for tobacco cessation counseling or services? Does this include just the provision of information or does the home visitor need to confirm the referral?

A: Home visiting models and programs determine what constitutes an appropriate referral for tobacco counseling or services in each community.

60. If the primary caregiver reports using tobacco at the time of enrollment but reports that they have or are currently receiving tobacco cessation counseling or services, is the program still required to make a referral?

A: Referrals should be tied to positive screenings during program services. If a primary caregiver reports tobacco use at the time of enrollment, they should be counted in the denominator once they have been enrolled for at least 3 months. To be counted in the numerator, the programs should provide a referral in response to the positive screening within 3 months of enrollment.

61. What is considered tobacco use? Do the use of betel nut, vaping, and tobacco use count?

A: Based on the referenced definition, tobacco or cigarette use consists of the following: combustibles (cigarettes, cigars, pipes, hookahs, bidis), non-combustibles (chew, dip, snuff, snus, and dissolvables), and Electronic Nicotine Delivery Systems (ENDS). Grantees must adhere to the referenced definition of tobacco substances, which corresponds with the CDC definition (<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6325a3.htm>).

Safe Sleep

62. How do we address monthly data collection with conflicting information? For example, the caregiver indicates safe sleep for 10 months and co-sleeping one time in the 11th month? Does this mean the participant should not be included in the numerator?

A: This measure may be assessed at numerous times throughout the reporting period. However, it is only required to be assessed once per reporting period. If measured at multiple points in time (such as by asking the primary caregiver during each visit), then the assessment completed closest to the end of the reporting period should be reported.

63. What if a child sleeps in the same bed as a sibling?

A: An index child sleeping in the same bed as a sibling is considered bed sharing and would not constitute a safe sleep practice.

64. We serve populations that regularly co-sleep as a cultural practice. How should we approach this measure with these families?

A: An index child sleeping in the same bed as a parent or sibling is considered bed sharing and should not be included in the numerator. While HRSA is sensitive to cultural practices regarding

co-sleeping, this practice does not align with current public health recommendations regarding safe sleep.

65. This measure requires the collection of multiple data points. Are there any recommendations for how to collect these data?

A: Safe sleep practices should be measured using primary caregiver-reported sleep practices throughout the index child's first year of life and may be measured once or at various times throughout the reporting period. In order to assess the measure accurately, the primary caregiver should be asked specifically if 1) she/he always places the index child to sleep on his/her back and 2) if she/he always places the index child to sleep without bed sharing or soft bedding. The primary caregiver needs to answer "yes" to both parts of the measure to be considered as having safe sleep habits.

Child Injury

66. Does the numerator include emergency department visits during the reporting period or only since the participant's enrollment?

A: Emergency department visits should be reported for the time they were enrolled within the current reporting period. Visits from prior reporting periods should not be included if the participant enrolled during a previous reporting period.

67. Older children may have more injury-related emergency department visits than infants due to their increased mobility. Will you take this into account?

A: HRSA understands that rates of child injury will vary due to a number of factors, including child age. However, reporting requirements specify that all nonfatal injury-related visits to the emergency department should be reported.

Child Maltreatment

68. Can child maltreatment be self-reported by the parent or are we required to use administrative data?

A: Data regarding child maltreatment must be collected using administrative data.

69. Does the numerator include child maltreatment cases during the reporting period or only since the participant's enrollment?

A: This measure captures index children with at least one investigated case of maltreatment during the reporting period, regardless of the disposition or outcome of the investigation. This measure is reported for each reporting period for which the index child is enrolled. Data reported during each reporting period reflect the period of time enrolled during that reporting period only, not cumulatively across all years enrolled. Investigated cases will only be reported during the year in

which they were opened; they will not be reported in subsequent years, regardless of the status of the case.

70. Does the denominator only include children enrolled during the reporting period?

A: Yes; the denominator should include children or families who are enrolled during the current reporting period. Participants who were enrolled in previous reporting periods but did not receive services for any length of time during the current reporting period will not be included in the denominator.

71. We collect data with a separate consent process for CPS data. We have previously limited the denominator to those who have signed a consent form. Is HRSA suggesting that those who did not sign a consent be in the denominator?

A: HRSA requires that all data that are reported on Form 2 be collected from participants who are voluntarily enrolled in the home visiting program and who have provided informed consent, no matter the source of the data.

72. We serve two sovereign nations, so we have three different policies to follow including the policies from the child welfare agency. Do we need to collect data from all three entities?

A: Yes, data should be collected from all applicable administrative data sources so that child maltreatment data may be reported for all children or families who are enrolled during the reporting period.

73. Should we include cases that are investigated or only those that are assessed?

A: This measure captures index children with investigated cases of maltreatment, regardless of the disposition or outcome of the investigation. Therefore, only include cases that are investigated.

74. If a case is reported and investigated, but no maltreatment found, would that be reported in the investigation?

A: Yes; this measure captures index children with investigated cases of maltreatment, regardless of the disposition or outcome of the investigation.

Caregiver-Child Interaction

75. We previously struggled to complete observations of caregiver-child interactions for children under 6 months because they are not as mobile or interactive during home visits. Can children under a particular age be excluded from this measure?

A: Grantees have discretion to select their own caregiver-child interaction observation tool as long as they use a validated tool, adhere to the training and administration requirements of the tool, and continue to adhere to model guidelines. Therefore, grantees should only include index children within the target age range(s) of the tool(s) that are used.

76. We currently have multiple LIAs using different caregiver-child observation tools and each tool has a different target age range for each child. Do we need to use the same observational tool and the same target age range across all our LIAs?

A: No; grantees do not need to use the same observational tool and target age range across all LIAs. Grantees are only required to track that at least one observation of caregiver-child interaction occurred with a validated tool in the reporting period, regardless of the tool used by each LIA.

77. Does the denominator include only a single caregiver per household?

A: This measure captures the interaction between the primary caregiver and the index child. There may only be one primary caregiver per household (regardless of the number of caregivers enrolled).

78. What is the desired age range for assessing parent-child interaction?

A: The desired age range will depend on the validated tool that grantees select to assess caregiver-child interaction. Grantees should adhere to the administration requirements of the tool they select and only include index children within the target age range(s) of the tool(s) that are used.

Early Language and Literacy

79. Are there any restrictions on the age of the child for this measure?

A: No; there are no age restrictions for including children in the early language and literacy measure.

80. When and how often should these data be collected?

A: Grantees may collect data as frequently as they choose, provided that they assess early language and literacy activities with families at least once during each reporting period. Grantees assessing index children's language and literacy at multiple age ranges should report data collected from the assessment completed closest to the end of the reporting period.

81. Since this measure includes multiple criteria, are there any recommendations for how to collect these data?

A: To accurately assess this measure, caregivers should be asked if their index children were 1) read to, 2) told stories to, and/or 3) sang songs to every day during a typical week. Note that the measure asks parents to reflect on a typical week and then to report if at least one of the activities occurred each day during the week. Any combination of these activities over the week meets the criteria. Although this measure may be collected at multiple data collection intervals,

the data collection time point completed closest to the end of the reporting period should be used for reporting on the measure.

82. If families are enrolled through two reporting periods, will they be counted multiple times?

A: Yes; and those families should receive at least one assessment during each reporting period.

Developmental Screening

83. Do index children have to receive one screening within each of the AAP-recommended age groups or do they only have to receive at least one screening that fell within an AAP-recommended age group?

A: Index children within the target age must receive at least one screening at an AAP-recommended age during the reporting period.

84. We currently assess index children multiple times at multiple age ranges. Which age range should we include?

A: Index children should be screened at the AAP-recommended ages of 9-months, 18-months, and 24- or 30-months. Grantees may choose to screen at additional ages but are expected to report on screenings at these specified ages. For families whose index children are being assessed at multiple ages within a reporting period, grantees should report on screenings at the AAP-recommended ages that are completed at the assessment closest to the end of the reporting period.

85. Is there a window for completing a screening that is acceptable?

A: Grantees will need to screen index children for developmental delays at each AAP-recommended age. The AAP recommends that, at a minimum, standardized developmental screening tools should be administered at 9-months of age, 18-months, and 24- or 30-months. AAP guidelines can be found on <http://pediatrics.aappublications.org/content/118/1/405.full>. Grantees should ensure index children are screened at the AAP-recommended ages within the administration window of the selected tool. For example, a tool may require the 9-month screener to be administered between the window of 8 months 0 days and 9 months 30 days.

86. Some of the models require developmental screenings be conducted during times that do not align with the AAP recommendations. Can we use multiple screenings during that interval?

A: Grantees may choose to screen at additional ages but are expected to report on screenings at the AAP-recommended ages. If grantees choose to screen at additional ages beyond the AAP recommendations, only data about screenings based on the AAP recommendations should be reported.

Behavioral Concerns

87. Is there guidance on when and how often to collect these data?

A: This measure requires that home visitors document if they did or did not ask the primary caregiver about developmental, behavioral, or learning concerns during **each postnatal home visit**.

88. If this is not asked at every home visit or missed on a single home visit, is this construct considered not met for a family?

A: The measure reports the proportion of all postnatal home visits where home visitors asked primary caregivers about behavioral concerns. Therefore, all postnatal home visits will be counted in the denominator and only those where the assessment occurred will be included in the numerator.

89. Should this be limited to caregivers with a index child of a certain age since behavioral concerns may vary by age?

A: There are no age restrictions for collecting data on behavioral concerns. This question must be asked at all postnatal home visits regardless of the index child's age.

90. If an adult participant is pregnant, will home visits during pregnancy count?

A: No; this measure excludes prenatal home visits.

Intimate Partner Violence Screening

91. Is the screening required once per reporting period, or once during the family's length of enrollment?

A: For the purposes of reporting, the screening should occur once during the first 6 months of enrollment.

92. Home visitors are confused about using the IPV screening when the person is not in an intimate partnership. Do we exclude participants who are not in an intimate partnership?

A: All primary caregivers should be screened for IPV, regardless of their relationship status. The definition of IPV includes any "person with whom one has a close personal relationship" and can be found at <http://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html>.

Primary Caregiver Education

93. How should we address the education status of participants who are enrolled for multiple years?

A: Primary caregivers who did not have a high school degree or equivalent at enrollment will be assessed for this measure during each reporting period for which they are enrolled. This measure may be assessed in multiple reporting periods per primary caregiver. Primary caregivers who are eligible to be included in the denominator will be included in each annual report until the conditions in the numerator have been met. This means that a primary caregiver may be included in more than one annual report. However, once the condition in the numerator is met, the primary caregiver will not be assessed in subsequent reporting periods. In other words, if a primary caregiver completes a high school degree or equivalent in a prior reporting period, they will not be counted in the current reporting period.

94. What is considered an “equivalent” for a high school degree?

A: Grantees must adhere to the Department of Education definition of recognized equivalent of a high school degree.

(<http://www2.ed.gov/policy/highered/reg/hearulemaking/2009/hsdiploma.html#red>)

95. Many of our participants already have a high school degree, can we count an alternate education requirement? For example, enrolling in continuing education such as college?

A: No; participants who already have a high school degree or equivalent do not meet the eligibility criteria for this measure which focuses on enrollment in, continuous enrollment in, or completion of a high school degree or equivalent among those who did not have a high school degree or equivalent at the time of enrollment into the home visiting program.

96. May this be asked once per year retrospectively (e.g. in September) instead of at every visit?

A: Yes; this measure may be assessed at or near the end of the reporting period rather than at each visit.

Continuity of Insurance Coverage

97. How is HRSA recommending states measure continuous enrollment?

A: Continuous enrollment in health insurance for 6 consecutive months may be assessed in several ways, either 1) retrospectively at the end of the reporting period by directly asking primary caregivers how many months they have had continuous health insurance coverage (e.g., no gaps in coverage) each reporting period, or 2) through routinely checking the health insurance status for each month to determine whether or not the primary caregiver maintained health insurance for 6 consecutive months during each reporting period. The latter approach allows for programs to support families in obtaining eligible coverage earlier during their enrollment in the program.

98. Do the cumulative 6 months need to be within the current reporting period? What if the 6 months overlap with another reporting period?

A: The 6 consecutive months of health insurance coverage may overlap reporting periods and do not need to occur in the same reporting period.

Completed Depression Referrals

99. What is included for “recommended services for depression”?

A: Recommended services for depression should be defined by home visiting models or state guidance about what constitutes a referral. For caregivers that screen positive for depression, the home visitor should provide the caregiver a referral to recommended services for depression.

100. Should the denominator definition include “within 3 months of enrollment or within 3 months of delivery”?

A: For consistency with the depression screening measure the denominator for completed referrals should be the number of primary caregivers enrolled in home visiting who had a positive screen for depression within 3 months of enrollment (for those not enrolled prenatally) or within 3 months of delivery (for those enrolled prenatally) and were referred for services. This has been clarified in the performance measures, which can be found at the following website: <http://www.mchb.hrsa.gov/programs/homevisiting/ta/resources/index.html>.

101. Is this “ever” received services? Or within a certain time frame?

A: There is no specified time frame for when the receipt of services needs to be met, as long as it occurred after the positive screen and referral for services. It is possible that the receipt of recommended services for depression would fall into a different reporting period than the screening and/or referral for services. As such, the denominator and numerator do not need to include an identical target population as Measure 3 since the depression screening can take place in a previous reporting period from the receipt of services.

102. Can we exclude those who have already been referred to depression/mental health treatment services by another provider prior to screening?

A: For those participants who screen positive for depressive symptoms but are already receiving services for depression, the program does not need to provide a referral. If the program does not make a referral, the participant does not need to be counted in this measure.

Completed Developmental Referrals

103. Why does receiving developmental guidance from a home visitor count as a “completed developmental referral”?

A: In order to be counted in the numerator, one of three conditions must be met:

(a) Received individualized developmental support from a home visitor: This is a home visitor-delivered, specific developmental promotion to address the area of concern. This can include more frequent screening, activities by model curriculum, ASQ activities, and CDC materials to target the developmental skill or domain for which there was a concern or positive screen.

(b) Received a referral to early intervention services and received an evaluation or individualized service plan within 45 days of that referral: This refers to index children with developmental and behavioral concerns that meet the criteria for referral to Part B or Part C early intervention services. The criteria for referral to Part B and Part C early intervention services vary by state and locale. Each program will need to learn what local criteria are for referring index children to Part B and Part C early intervention services and identify index children that meet those criteria.

(c) Received a referral to other community services and received services from that provider within 30 days: This includes any services available that provide developmentally-enhancing support to index children and families that do not fall under the funding/reimbursement system for Part B or Part C early intervention services. Examples include drop-in centers, parent-child groups, early literacy supports, and parent training. This may also include early childhood mental health treatment.

104. Is this “ever” received services? Or within a certain time frame?

A: Grantees may include participants who received services within the time frames specified for the conditions in the numerator. While the receipt of individualized developmental support from a home visitor does not have a specified time frame, receipt of services following a referral to early intervention services needs to be completed within 45 days and the receipt of services following a referral to other community services needs to be completed within 30 days.

105. What is the window between a positive screen and a referral in order to be counted?

A: While there is no window between the positive screen and the date of the referral, there is a window between the referral and the completion of services for early intervention and other community services as specified in the definition of the numerator.

106. For “completed referrals”, is the positive screen required during the reporting period or does it include a positive screen at any time?

A: The positive screening does not have to occur in the same reporting period as the completed referral.

107. If an index child screens positive for developmental delays but is already enrolled in services, do we have to provide another referral?

A: If an index child screens positive for developmental delays, they must be included in this measure. One of three conditions must be met by the program to be counted in the numerator. For example, if an index child is already receiving early intervention services (condition b), then the program may provide individualized developmental support from the home visitor (condition a).

108. There are three conditions specified in the numerator. Please clarify if the numerator definition indicates that one of the three components need to be met (a or b or c)? Or that either the first two components need to be met or the third component needs to be met (a and b or c)?

A: Any one of the three conditions can be met in order to count in the numerator: (a) received individualized developmental support from a home visitor, or b) were referred to early intervention services and receive an evaluation within 45 days, or c) were referred to other community services who received services within 30 days).

Intimate Partner Violence Referrals

109. Does receipt of IPV referral information need to occur within the reporting period in order to be counted?

A: The receipt of IPV referral information will be counted in the numerator in the reporting period in which it occurs. The screening must occur within 6 months of enrollment. There is no specific time frame for when the referral should occur, and it could occur in a different reporting period than the screening. Primary caregivers will be eligible to be included in the denominator once a positive screening occurs and will be included in the denominator of each annual report until the conditions in the numerator have been met. This means that a primary caregiver may be included in more than one annual report.

110. How is “received referral information” defined for this measure?

A: Received referral information means that the primary caregiver was provided information about IPV community resources by the home visitor.

111. With regards to the denominator, can we exclude those who have already received a referral or are receiving services prior to home visiting?

A: Programs are expected to screen all primary caregivers for IPV within 6 months of enrollment. If a primary caregiver screens positive for IPV after enrollment, the program is expected to provide referral information regardless of whether or not the primary caregiver previously received a referral for services prior to enrolling in the home visiting program.